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attack brought on a tendency to cure by increasing the circulation of blood through the exhausted brain. A slight degree of stupor more frequently precedes recovery, as in convalescence from acute mania. A mixture of maniacal and stuporous conditions is less favorable, or a tendency towards histrionic and pathetic displays, or the occurrence of pseudo-tetanic or pseudo-cataleptic states. Latter symptoms approximate Catatonia, which indeed is probably to be regarded as a variety of the general affection under consideration. As in all acute insanities death from exhaustion may occur in the early stage, and in debilitated sufferers there is a tendency to succumb to intercurrent affections. The diagnosis lies between acute mania, acute melancholia, acute dementia, and certain forms of paranoia. From mania it is distinguished by absence of exaltation and of increased rapidity of thought. (Norman, with Salgó, would exclude from mania any case with hallucinations). True emotional depression as a primary symptom is absent in acute confusion, distinguishing it from melancholia. It is intimately associated with acute dementia, and it is not always possible to say which form we are dealing with, though the presence of hallucinations and absence of complete stupor in a typical case of complete confusion sufficiently denote the ailment. Distinguished from paranoia by want of systematization of delusions, by existence of confusion, and by sudden mode of origin.

Norman repeats nine cases as follows:

- I. Acute confusion, associated with alcoholic excess. Neuritic pains; recovery.
- II. Acute hallucinatory confusion, associated with alcoholic excess; epileptiform seizures; recovery. "An extremely typical case of alcoholism in a woman."
- III. Acute hallucinatory confusion associated with alcoholic excess.
- IV. Confusion in the special form described by Ross and Wigglesworth occurring in a toper. Passage into secondary dementia.
- V. Acute hallucinatory confusion resembling paranoia, associated with alcoholic excess. Recovery.
- VI. Acute hallucinatory confusion simulating paranoia, following rheumatism and perhaps associated with nostalgia. Recovery.
- VII. Hallucinatory confusion associated with phthisis.
- VIII. Acute hallucinatory confusion dependent perhaps upon nostalgia. Passage into dementia.
- IX. Acute hallucinatory confusion beginning in a dream. Apparent cause, sexual irregularity.

Norman cites Korsakoff's articles and considers that they are both describing the same form of mental disturbance.

*Folie post-opératoire.* PROF. MAIRET. *Le Bulletin Medical*, 1889; Aug. 28 and Sept. 1.

Prof. Mairet studies the mode of evolution of insanity following operations rather than the form of the insanity itself. He adds one case to literature, that of a woman of 42 who became insane three days after a laparotomy. Patient was intelligent and vivacious, but without hereditary or degenerative nervous taint. At 22, after childbirth, she suffered from attacks of hysteria with syncope, without absolute loss of consciousness, but with delusional troubles following, and hallucinations of sight and hearing; attacks sometimes lasted minutes, at other times hours; troubles appeared with menses. Intellect unimpaired, and she retained the management of her household. At 39 abdominal trouble appeared, necessitating laparotomy three years later. Three days after the operation began to laugh without motive and to have hallucinations of hearing. Delusions increased and patient admitted to asylum three months and a half after operation. Torpor and intellectual wandering

were most noticeable. Marked failure in nutrition. Refused to eat. Died of exhaustion 35 days after admission.

Mairét raises the question whether the sudden appearance of the mental trouble after the operation was simply a coincidence, or if the operation had a distinct etiological relation, and decides in favor of the etiological relationship. He finds in literature 24 cases where insanity followed operation, but admits that the list may not be complete. In analyzing these cases he finds that the rôle of the operation may be a variable one, being at times only an occasional cause, as in an operation in a case of alcoholism, while in other cases the operation plays a considerable part. There was considerable predisposition in his own case, while in a case reported by Herm-Lossen and Fuerstner the etiological importance of the operation was still greater, and the predisposition much less, there being no nervous predisposition except a chorea at the age of 14. In reviewing the cases Mairét reaches the conclusion that a certain amount of predisposition is always necessary, and that a surgical operation by itself is not capable of producing insanity. While the most different operations may be followed by insanity, are all operations susceptible in the same degree of producing it? It is the grave operations, especially those on abdominal viscera, that cause insanity without there being a strong predisposition. Werth reports the following results: Two cases of insanity in 32 hysterectomies, or 6%; two in 36 castrations, or 5.55%; and only two in 160 ovariectomies. Regarding the manner in which surgical operations produce insanity Mairét holds that in a surgical operation of considerable importance the surgical traumatism and its sequelæ are not the sole elements susceptible of working on the brain and thus developing insanity. For a certain time before the operation the patient is preoccupied; he dreads the operation, and his mind is in a state of tension that particularly favors the development of insanity. The anaesthetics, too, have a particularly strong action on the nervous system, and especially upon the brain. After the operation the surgeon uses in the dressings substances such as iodoform, which are in themselves capable of producing mental troubles; and finally, after the operation the patient must be excited by stimulants, particularly by alcoholic drinks. Mairét is convinced that insanity after operations is the result of these different causes, or at least of several of them. Although he attaches but slight importance to iodoform, he attaches much to the etiological influence of anaesthetics.

In cases where the predisposition is feeble it is necessary to go to the operation itself, as such, to explain the development of the insanity, but the published facts are too few to assist in ascertaining how the operation works. It is not so much the operation itself, properly so called, as it is that the traumatism is succeeded by a more or less extended and severe wound. In the cases reported the operation itself and its sequelæ have been absolutely regular. It is on the side of the nutrition that it is necessary to look for the reason of the action of the traumatism. In Mariet's case the troubles in nutrition appeared directly after the operation, but the observations are too few to say that this is always the case. This was markedly the case in Shepard's two cases. However this may be, the troubles of nutrition when they exist put the nervous system in a state of morbid receptivity which allows the passing delirium which the anaesthetics and the other causes may produce, to pass into a chronic state and to favor the production of true insanity.

As regards the time of onset of the mental disturbance, this may come on immediately after the operation, but generally it is not until several days, usually on the 3d or 5th day, or at least within the first week that the patient is perceived to be strange and to have lost his mental equilibrium. Sometimes, however, the mental troubles do not appear until later. Werth reports cases in the 2d, 3d and 5th weeks. Usually the

development takes place progressively—a modification of character and illusions appearing first, then agitation is added, and finally after a longer or shorter time, days or weeks, the insanity is definitely established. More rarely the insanity sets in suddenly without prodromes. Meredith reports a case where an acute melancholia appeared suddenly at the beginning of the 4th week.

Post-operative insanity has different forms, and here must be distinguished the cases in which the operation acts only as a provoking cause and those in which its pathogenic influence is considerable. When the operation plays only the rôle of an occasional cause the form which the insanity takes is dependent not on the traumatism but on the anterior state, which may be of a very variable nature. In one case it may be a very powerful predisposition or an intoxication, or in another case it may be a typhoid fever which modifies the central nervous system. When the pathogenic influence is most powerful the forms which are generally found are mania and melancholia, but the observations are too few to say if the mania or melancholia have a special physiognomy. [Wood's remarks on this subject seem to be of much greater value.]

As regards prognosis this depends largely on whether the operation plays the part of a primary or an occasional cause, being more grave where the antecedent predisposition is more marked, and where the nutrition is poor, and here leading to incurable insanity or to death.

In summing up the whole subject Mairret concludes:

1°. It is among the predisposed individuals, predisposed either by heredity or any other cause (alcoholism, infectious diseases, etc.), that surgical operations give rise to insanity.

2°. Among the constituent elements of an operation that may act on the brain the two most important from the point of view of the development of insanity are anaesthetics and surgical traumatism with their sequelæ, chief among which are the troubles of nutrition.

3°. When the predisposition is considerable the anaesthetics may of themselves alone set this into activity and cause the appearance of insanity, so that the less important operations, acting as surgical traumatism, may give rise to insanity.

These points should govern the conduct of the physician in interfering surgically in predisposed individuals. Among these individuals one ought not to undertake an operation of any consequence except when there is a vital necessity, and when it has once been decided upon, anaesthetics, at least general anaesthetics, should be omitted if possible. [It need scarcely be pointed out that Prof. Mairret goes to extremes that few or any would care to follow in ascribing such overwhelming importance to anaesthetics. Were anaesthetics withheld to the extent he advocates, from the remote possibility of mental disturbance, much needless suffering could not fail to result.]

*Insanity following Surgical Operations.* LAWSON TAIT. *British Medical Journal*, Aug. 31, 1889. (Abstracted in *Dublin Journal of Medical Science*, 1890, I, 250.)

This is a criticism of the book of Dr. E. Denis on this subject. Tait says that he has performed between 7,000 and 8,000 operations, requiring the use of anaesthetics, and has had anaesthetics administered in cases not involving traumatism in 3,000 more instances, and he knows of only seven cases of sequent—not necessarily consequent—insanity. There may have been other cases, and he will say 14 cases to cover the margin of error. His own practice therefore does not yield a proportion of cases of insanity following operations larger than the general proportion of insanity in the female adult population, and including the cases of anaesthesia is probably considerably smaller. Dr. Denis gets an average of 2.5 cases of alienation in 100 operations. But if this had been the case